Move It CHIROPRACTIC
Our family caring for your family.

Confidential Adult Patient Information & History Form

Welcome to Move It Chiropractic. Please complete this form to the best of your ability & add any additional notes/information you feel would be beneficial for the Doctor to know to assist you most effectively.

PATIENT INFORMATION

Today's Date: _____ / _____ / _________ First Name: ____________________ Last Name: ____________________

Preferred Name: ____________________ Date of Birth: ____________________ Age: ____________________

Mobile #: ____________________ Home #: ____________________ Work #: ____________________

Email: ____

Emergency Contact: ____________________ Contact Number: ____________________ Relationship: ____________________

Occupation: ____________________ Employer/School: ____

Home Address: ____

Suburb: ____________________ State: ____________________ Postcode: ____________________

Partner Name: ____________________ Children Names: ____________________

We appreciate referrals, who may we thank for referring you? ☐ Person (please specify) ____________________

☐ Online Search ☐ Website ☐ Facebook ☐ Signage ☐ Medical Practitioner ☐ Other ____________________

Private Health Fund: ____________________ Member Number: ____________________

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Medicare Ref Number (number beside your name): ☐

Do any of the following apply for this visit: ☐ Pensioner ☐ Workers Comp ☐ DVA ☐ ECP/Medicare

Have you had chiropractic care before? ☐ No ☐ Yes (by whom) ____________________ (in what year) __________

Have you previously had any X-Rays taken? ☐ No ☐ Yes (year taken) __________ (area of the body) __________

HOW CAN WE HELP YOU?

What brings you to us today? ____

____

If you are already experiencing any symptoms, what are they? ____________________

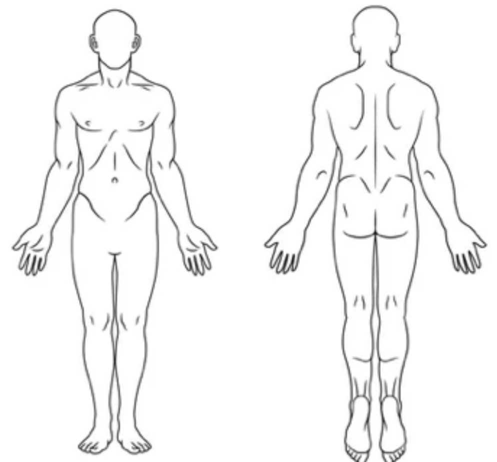
____

How intense are your symptoms? No Symptoms

0	1	2	3	4	5	6	7	8	9	10

Intense Symptoms

Please circle any areas where you have pain or other symptoms



What does it feel like? (please check where appropriate)

☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing
☐ Cramping ☐ Swelling
☐ Nagging ☐ Other ____________________

Any other problems you are concerned with:

____

PTO

IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (please check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ____________	☐	☐	☐	☐

How committed are you to correcting this issue?

Not Committed	0	1	2	3	4	5	6	7	8	9	10	Very Committed

What are your health goals?

IMMEDIATE: ____________

SHORT TERM: ____________

LONG TERM: ____________

CHILDREN & PREGNANCY

How many children do you have? ____________

Children's Ages: ____________

Children's health concerns: ____________

Are you currently pregnant? ☐ No ☐ Yes, I am due ____________

Number of past pregnancies: ____________

Health concerns regarding this pregnancy: ____________

HEALTH & ILLNESS HISTORY

Sporting & exercise programs: ____________

Hobbies: ____________

Accidents & injuries: ____________

Operations: ____________

Medications/supplements: ____________

Do your sleeping patterns seem normal? ☐ Yes ☐ No Hours per day ____________

How would you rate your quality of sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What position do you sleep in? ☐ Back ☐ Side ☐ Stomach

(please check where appropriate)

- ☐ Abdominal pain or digestive problems
- ☐ Allergies, asthma, or hay fever
- ☐ Anxiety, depression, stress, or psychological problems
- ☐ Arthritis or orthopaedic problems
- ☐ Cancer or tumours
- ☐ Diabetes
- ☐ Epilepsy or neurological problems
- ☐ Headaches, migraines, or dizziness
- ☐ Kidney or bladder problems
- ☐ Low energy, fatigue, or trouble with sleep
- ☐ Lung or breathing problems
- ☐ Sinus, vision, or hearing problems
- ☐ Endometriosis, period pain, or menstrual issues
- ☐ Other ____________